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IN THE

Supreme Court of the United States

OCTOBER TERM, 1996

KIMBERLY BELSHÉ, Director of the State Department of Health Services, State of California

Petitioner,

vs.

ORTHOPAEDIC HOSPITAL and the CALIFORNIA ASSOCIATION OF HOSPITALS AND HEALTH SYSTEMS

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF OF 16 STATE AMICI CURIAE SUPPORTING PETITIONER

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QUESTIONS PRESENTED

1. Whether 42 U.S.C. § 1396a(a)(30)(A) imposes on States a methodology for Medicaid ratesetting that includes the obligation to conduct cost studies of hospital outpatient services and to set rates that are based on costs.

2. Whether 42 U.S.C. § 1396a(a)(30)(A) creates individual rights for health care providers enforceable under 42 U.S.C. § 1983.

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INTEREST OF AMICI CURIAE

The 16 States that join in this amicus brief all participate in the Medicaid program. Medicaid is a cooperative federal-state program that provides federal financial assistance to States for reimbursing certain costs of medical assistance to needy recipients. The States and the federal government expect to spend a total of $160 billion on the Medicaid program in Fiscal Year 1997, far in excess of spending for any other state or federal means-tested benefits program.[1/]

[1/] Pursuant to Supreme Court Rule 37.6, no counsel for any party authored this brief in whole or in part, and no person or entity other than

(continued...)

The decision below threatens substantial disruption to the Medicaid programs of the State *amici*. If the decision is followed, States would be faced with the need to engage in expensive and drawn out procedures whenever they contemplate adjusting the reimbursement rates for any one of scores of categories of services provided to Medicaid recipients. And because these procedures are essentially standardless, the State *amici* would face a flood of new litigation from providers seeking to use the courts to force more favorable reimbursement terms. Pursuant to Supreme Court Rule 37.2(a), counsel for the parties have consented to the filing of this amicus brief.

REASONS FOR GRANTING THE PETITION

BACKGROUND

Medicaid is an assistance program, jointly funded by federal and state governments, to pay for health care services for eligible recipients. States design and operate the program subject to a variety of federal policies and conditions, and determine the level of reimbursement payments for providers who serve Medicaid recipients. The general provision of the Medicaid Act applicable to payments for providers is 42 U.S.C. § 1396a(a)(30)(A), originally enacted as part of the Social Security Amendments of 1967, Pub. L. 90-248, § 237.[2/] Congress amended § 1396a(a)(30)(A) in 1981 to

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[1/](...continued)
the amici curiae made a monetary contribution to the preparation or submission of this brief.

[2/] The Medicaid Act includes a special provision, known as the Boren Amendment, which is addressed to setting rates for institutional providers of Medicaid services. *See* 42 U.S.C. § 1396a(a)(13)(A).

increase the flexibility of and to reduce the administrative burden on States, and amended it again in 1989 to add a provision concerning access to care. Throughout the three decades that § 1396a(a)(30)(A) has been part of the Medicaid Act, neither the current implementing federal agency—the Health Care Financing Administration ("HCFA") of the United States Department of Health and Human Services nor its precedessor—has promulgated any regulations under the authority of § 1396a(a)(30)(A), other than regulations setting ceilings on the levels of rates a State may pay. There are no regulations that set forth the procedural requirements imposed by the court below.

SUMMARY OF ARGUMENT

The State *amici* urge the Court to grant review in this case to resolve a conflict among the courts of appeals concerning the interpretation of an important provision of the Medicaid Act, 42 U.S.C. § 1396a(a)(30)(A). The Ninth Circuit's interpretation of that provision as requiring States to follow a particular methodology conflicts with recent decisions of the Seventh and Eighth Circuits that have found that the provision does *not* prescribe a particular methodology. There is no basis for the Ninth Circuit's interpretation in the statutory language, and it is inconsistent with the legislative history and the interpretation of the federal agency administering the statute. Further, the Ninth Circuit's intrusive, *de novo* review of the State's internal decisionmaking is directly contrary to decisions of this Court. Finally, § 1396a(a)(30)(A) lacks sufficient specificity and detail to create individual rights enforceable by health care providers under 42 U.S.C. § 1983.

I. THERE IS A CONFLICT IN THE CIRCUITS CONCERNING AN IMPORTANT ISSUE OF STATUTORY INTERPRETATION.

A. *The Ninth Circuit's Interpretation Of Section 1396a(a)(30)(A) Conflicts With That Of The Seventh and Eighth Circuits.*

The Ninth Circuit's interpretation of an important provision of the Medicaid Act, 42 U.S.C. § 1396a(a)(30)(A), directly conflicts with the interpretations of that provision in recent decisions of the Seventh and Eighth Circuits. Section 1396a(a)(30)(A) applies to the expenditure by the federal and state governments of billions of dollars of public funds for the Medicaid program. This Court's guidance on the issue is badly needed; the conflicting interpretations of the statute by courts of appeals, and the resulting uncertainties about the legal requirements that it may impose, threaten the States' effective administration of the Medicaid program.

There has been a flood of complex and expensive litigation in the 1990s brought by health care providers against States challenging the level of Medicaid reimbursement rates and the State's rate-setting procedures. An impetus to this movement was this Court's decision in *Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498 (1990). That case held that providers may bring actions under 42 U.S.C. § 1983 to enforce the provision of the Medicaid Act known as the Boren Amendment, which sets out payment standards for institutional providers of health services (such as inpatient hospital and nursing home services). 42 U.S.C. § 1396a(a)(13)(A).[3/]

[3/] The Boren Amendment was originally enacted as a part of the Omnibus Budget Reconciliation Act of 1980, Pub. L. No. 96–499, § 962(a), 94 Stat. 2599, 2650 (1980).

The Boren Amendment provides that a State Medicaid plan must

> provide ... for payment ... of the hospital services, nursing facility services, and services in an intermediate care facility for the mentally retarded ... through the use of rates (determined in accordance with methods and standards developed by this state ...) which the state finds and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal law ...

In recent years, providers of non-institutional services (such as physicians and hospital clinics) have urged courts to expand *Wilder* to permit private rights of action under § 1983 to challenge Medicaid rates for services that are *not* covered by the Boren Amendment. These providers have focused on a different provision of the Medicaid Act, 42 U.S.C. § 1396a(a)(30)(A), the only payment provision applicable to non-institutional providers.

Unlike the Boren Amendment, § 1396a(a)(30)(A) makes no reference to costs and sets forth neither a specific ratemaking standard nor a procedure for setting rates. It does not include the requirement for findings and assurances contained in the Boren Amendment. Rather, with regard to rates, it provides that a State Medicaid plan must

> provide such methods and procedures relating to ... the payment for care and services available under the plan ... as may

> be necessary ... to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.

This provision does not specify any methodology that the State must follow in setting rates. Rather, it is concerned solely with assuring that whatever rates are adopted "are consistent with efficiency, economy, and quality of care" and ensure sufficient access to providers.

In *Methodist Hospitals, Inc. v. Sullivan*, 91 F.3d 1026 (7th Cir. 1996), involving a challenge to Indiana's Medicaid rates for hospitals and physicians, the Seventh Circuit confirmed that § 1396a(a)(30)(A) "requires each state to produce a *result*, not to employ any particular methodology for getting there." *Id.* at 1030 (emphasis in original). The court found that "[u]nder § 1396a(a)(30), ... states may behave like other buyers of goods and services in the marketplace: they may say what they are willing to pay and see whether this brings forth an adequate supply. If not, the state may (and under § 1396a(a)(30), must) raise the price until the market clears." *Id.* The Seventh Circuit rejected the argument that the State must perform studies prior to changing its rates. It emphasized that "[n]othing in the language of § 1396a(a)(30), or any implementing regulation, requires a state to conduct studies in advance of every modification." *Id.* The Seventh Circuit recognized that such studies, which could involve preparing demand and supply schedules for every medical specialty, would be "impossible" for the state to accomplish. *Id.*

The Eighth Circuit's decision in *Minnesota Homecare Ass'n v. Gomez*, 108 F.3d 917 (8th Cir. 1997), followed, in which the court held that the Medicaid Act "does not require the State to utilize any prescribed method of analyzing and considering said factors" of efficiency, economy, quality of care and access to care in § 1396a(a)(30)(A). *Id.* at 918. The Eighth Circuit affirmed the district court's ruling that the State was not required to maintain a specified type of system for monitoring whether rates meet the goals of quality care and access to services as set forth in § 1396a(a)(30)(A).[4/]

The Ninth Circuit's decision sharply departs from the Seventh and Eighth Circuits' decisions in its focus on the correctness of the methodology chosen by the State to comply with the statute, instead of on whether the methodology produces results that comply with the statute. Without citing legal or factual authority, the Ninth Circuit imposed numerous requirements to govern the State's methodology. *E.g.*, Pet. App. A-13 ("payments for hospital outpatient services *must* bear a reasonable relationship to the costs of providing quality care"; "payments ... *must* approximate the cost of quality care provided efficiently and economically"); A-14 ("The Department *cannot* set rates ... without considering the costs to the hospitals") ("the Department *must* consider the costs of providing quality care"); A-19 ("the Department *must* consider hospitals' costs"); A-22 ("the Department *should undertake* responsible cost studies") (emphasis added). The

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[4/] The Eighth Circuit had previously interpreted § 1396a(a)(30)(A) in *Arkansas Medical Society, Inc. v. Reynolds*, 6 F.3d 519 (8th Cir. 1993), holding (in our view incorrectly) that providers had a private right of action to enforce that provision. Unlike the Ninth Circuit's decision, however, the court in *Reynolds* applied a deferential standard of review to the State's ratemaking decisions: "Review under the arbitrary and capricious standard is narrow, and a court may not substitute its judgment for that of the agency." *Id.* at 529.

Ninth Circuit even fashioned a new burden of proof, again without citing any authority: "The state must then set rates that have some reasonable relation to such costs [of hospital outpatient services], the state bearing the burden of justifying any rate that substantially deviates from such determined costs." Pet. App. A-22. This new set of requirements will impose enormous fiscal and administrative burdens on the State. Pet. Br. 22-26.

In imposing these requirements, the Ninth Circuit's concern was whether, in its opinion, the State "appropriately applied" the factors in § 1396a(a)(30)(A). Pet. App. A-22. In direct contrast to the Seventh Circuit's decision in *Methodist Hospitals*, the *results* of the application of those factors were irrelevant to the Ninth Circuit's reasoning. Significantly, the record in this case revealed no access or quality of care problems. The Ninth Circuit acknowledged that there "has been no assertion of a provider participation problem." Pet. App. A-17. Moreover, the district court found that "[t]here is no quality of care problem for Medi-Cal beneficiaries in California." Pet. App. B-20. These results should have been sufficient to demonstrate the State's compliance with § 1396a(a)(30)(A). But the court of appeals, despite acknowledging these outcomes, nonetheless invalidated the challenged rates based solely on the particulars of the methodology that the State used to establish the rates.

Ever since the *Wilder* decision, States have been confronted with burdensome litigation over the validity of their methods for establishing reimbursement rates for inpatient hospitals and nursing home services. Frequently, courts have enjoined the use of rates, without regard to their substantive sufficiency, based on challenges to some aspect of the State "findings" process, or because imaginative lawyers or consultants were able to persuade a court of one or more "factors" that a State did not adequately address before

adopting a particular rate.[5/] The Ninth Circuit's decision expands this type of judicial intervention to all aspects of Medicaid services, which would greatly disserve the purposes of the program as well as add many more "standardless" cases to the dockets of both state and federal courts.

B. *There Is No Basis For The Ninth Circuit's Interpretation of § 1396a(a)(30)(A) In The Statutory Language Or In Its Legislative Or Regulatory History.*

Section 1396a(a)(30)(A) is concerned with results—it seeks to assure that Medicaid payments are consistent with economy, efficiency, and quality of care and provide for sufficient access to providers. Nowhere in the language of § 1396a(a)(30)(A) is there any requirement that Medicaid payments be consistent with costs of efficient providers. The provision, unlike the Boren Amendment (42 U.S.C. § 1396a(a)(13)(A)), makes no reference to costs at all.

Nor can the cost standard imposed by the Ninth Circuit be reasonably implied from the language of § 1396a(a)(30)(A). It is entirely possible for a State to comply in full with this section without basing its level of payment on studies of provider costs. A State may choose to assure consistency with quality of care through its regulatory scheme set up to monitor

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[5/] *See, e.g., Abbeville General Hospital v. Ramsey*, 3 F.3d 797 (5th Cir. 1993); *Temple Univ. v. White*, 941 F.2d 201 (3d Cir. 1991); *Pinnacle Nursing Home v. Axelrod*, 928 F.2d 1306 (2d Cir. 1991); *Oklahoma Nursing Home Ass'n v. Demps*, 816 F. Supp. 688 (W.D. Okla. 1992); *Rye Psychiatric Hosp. Ctr. v. Surles*, 768 F. Supp. 82 (S.D.N.Y. 1991); *Multicare Med. Ctr. v. Washington*, 768 F. Supp. 1349 (W.D. Wash. 1991); *Missouri Health Care Ass'n v. Stangler*, 765 F. Supp. 1413 (W.D. Mo. 1991); *Department of Health & Soc. Servs. v. Alaska State Hosp. & Nursing Home Ass'n*, 856 P.2d 755 (Alaska 1993).

quality of care. A State may choose to assure sufficient access by actions that affect the number of participating physicians, geographic location, travel time, and utilization rates. Sufficiency of access may also be monitored by reference to the rates of other payers (such as private insurers). A State may determine that its payments are consistent with efficiency and economy by its compliance with federal regulations setting certain upper limits on the amount of payments. *See* 42 C.F.R. §§ 447.304, 447.321–447.334, 447.361. Or, as the Seventh Circuit has found, a State may "say what they are willing to pay and see whether this brings forth an adequate supply. If not, the state may (and under § 1396a(a)(30), must) raise the price until the market clears." *Methodist Hospitals*, 91 F.3d at 1030. All of these approaches are consistent with the statute, and none of them requires an analysis of provider costs. As the district court here correctly found, if payments are sufficient to ensure quality of care and sufficient access, "it is irrelevant whether hospitals make or lose money treating Medi-Cal beneficiaries." Pet. App. B–16. The Ninth Circuit is incorrect to conclude that a State "cannot possibly conclude that there is a rational relationship of those factors [in § 1396a(a)(30)(A)]" without considering hospitals' costs. Pet. App. A–22.[6/]

[6/] The Ninth Circuit seemed swayed by the fact that hospitals participating in the Medicaid program are bound to accept all emergency cases without regard to ability to pay. The court opined that since Medicaid recipients were not being induced to use other providers, hospitals were entitled to be paid by reference to their own costs of service, even though those costs might be greater than alternative providers if they maintain emergency rooms. There are many faults in this analysis. No such viewpoint is expressed or fairly implied in the statute or its legislative history, nor in any of the regulations or commentary of HCFA, the administering federal agency. Moreover, California's rates do include a separate supplement available to hospitals but not to alternative providers. As a result, hospitals

(continued...)

The Ninth Circuit's interpretation not only has no basis in the legislative history of § 1396a(a)(30)(A), it is directly at cross-purposes with that history. Congress amended § 1396a(a)(30)(A) in 1981 to remove language that prohibited States from making Medicaid payments in excess of a prescribed Medicare "reasonable charge" level. *See* H.R. Rep. No. 97-158, vol. II, at 312-13 (1981).[7/] The House Budget Committee Report sets forth two purposes for the change: increasing the flexibility of States to implement the goals of the provision and reducing the administrative burden of States. *Id.* First, the Committee intended "to provide States with the flexibility to create incentives to improve the availability and utilization of physician services under medicaid." *Id.* The Committee believed that repeal of the reasonable charges ceiling would give States the necessary freedom to be creative and design incentives to reach national health policy goals. *Id.* at 313. Second, the Committee intended "to remove the administrative burdens this requirement of current law imposes on the States." In doing so, the Committee was responding to reports of problems experienced by some States in obtaining data necessary to calculate their rates. *Id.* at 312.

[6/](...continued)
receive twice as much reimbursement as alternative providers of similar services, a fact overlooked by the court of appeals. 3 AR 41.

[7/] As originally enacted in 1967, § 1396a(a)(30)(A) required state plans to "provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments . . . are not in excess of reasonable charges consistent with efficiency, economy and quality of care." Pub. L. 90-248, § 237. Congress deleted the "in excess of reasonable charges" language in 1981.

Thus, the Budget Report emphasized the States' flexibility and freedom to innovate as a primary goal, and eschewed administrative requirements as undesirable and harmful. Despite its recognition of the Budget Committee's two-pronged goals, the Ninth Circuit interpreted that Report as support for a requirement that States connect their payments to actual costs. The effect of this interpretation is to limit severely States' flexibility to create and to implement policies designed to improve provider access. The Ninth Circuit's conclusion is also inconsistent with the Committee's purposes because it creates high administrative hurdles, which include the expensive, time-consuming, and difficult task of collecting extensive data on the costs of hospital outpatient services. The Ninth Circuit thus interprets the statute so as to undermine Congress' intent: in place of the increased flexibility and reduced administrative burden envisioned by Congress, the Ninth Circuit's holding will reduce flexibility and increase administrative burden.

Congress has linked payment adequacy to provider costs only in the context of institutional providers only through the Boren Amendment. That provision had been on the books for nine years when Congress amended § 1396a(a)(30)(A) in 1989. Moreover, in the same 1989 legislation that amended § 1396a(a)(30)(A) to add the access provision, Congress enacted a provision pertaining to access to non-institutional obstetrical and pediatric services, requiring States to submit detailed information to HHS about payment rates for those services and other relevant data to enable HHS to evaluate the States' compliance with that provision. *See* Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6402(b), 103 Stat. 2106, 2260-62, *codified at* 42 U.S.C. § 1396r-7. Congress chose to carve out specific methodological requirements only for obstetrical and pediatric services; it did

not see fit to mandate them for any other services.[8/] The Ninth Circuit's addition of methodological requirements by judicial interpretation is not faithful to the intent of Congress as reflected by this history.[9/]

The Ninth Circuit's holding is also inconsistent with the longstanding interpretation of § 1396a(a)(30)(A) by HCFA, the federal agency charged with administering the statute. HCFA has long adopted the position that States should have flexibility in their methods for implementing the goals of § 1396a(a)(30)(A), and it has never adopted regulations specifying any methodological requirements for State ratemaking for non-institutional providers. *See* 42 C.F.R.

[8/] Even the additional requirements imposed by Congress in § 1396r-7 do not require the cost standards that the Ninth Circuit read into § 1396a(a)(30)(A).

[9/] There are reasons why methodologies that may be thought appropriate in setting Medicaid rates for institutional providers like hospitals and nursing homes are not necessarily appropriate in the context of setting rates for non-institutional providers. Institutional providers submit detailed cost reports and there are elaborate cost-finding conventions applicable to them that permit cost-based analyses. Moreover, a more particularized rate standard could be seen as providing some assurance of continued revenue to justify capital commitments made by these institutional facilities. In contrast, non-institutional providers, which include individual practitioners like physicians, dentists, nurses, and therapists, do not typically prepare cost reports and are not so dependent on capital investment. Outpatient hospital services, although somewhat of a hybrid, bear more resemblance to physician services in a clinic than to inpatient hospital services. Thus, these services appropriately have been treated as non-institutional services and covered by § 1396a(a)(30)(A), not the Boren Amendment. *See State of New York by Perales v. Bowen*, 811 F.2d 776, 778 (2d Cir. 1987); *Michigan Hosp. Ass'n v. Department of Soc. Servs.*, 555 F. Supp. 675, 677 (E.D. Mich. 1983); *but see Ohio Hosp. Ass'n v. Ohio Dep't of Human Servs.*, 1990 Ohio App. LEXIS 2587 at *23 (June 21, 1990).

§§ 447.304, 447.321–447.334, 447.361; 46 Fed. Reg. 47964 (Sept. 30, 1981); 46 Fed. Reg. 48556 (Oct. 1, 1981).

II. THE NINTH CIRCUIT'S APPROACH IS CONTRARY TO THIS COURT'S DECISIONS CONCERNING THE ROLE OF JUDICIAL REVIEW OF ADMINISTRATIVE DECISIONS.

The Ninth Circuit's decision engages in a detailed assessment of the wisdom of California's Medicaid policies, based on its own views of appropriate health policy. Pet. App. A–12 to A–22. This highly intrusive review of agency decisionmaking is squarely contrary to decisions of this Court and is a separate reason favoring the grant of certiorari.

Under *Chevron U.S.A. v. Natural Resources Defense Council*, 467 U.S. 837, 842–43 (1984), courts are to defer to the administrative interpretation of a statute where Congress has not directly spoken to the precise question at issue. Here, the Ninth Circuit erred by failing to accord *Chevron* deference to HCFA's interpretation of § 1396a(a)(30)(A). *See, e.g., Visiting Nurse Ass'n of North Shore v. Bullen*, 93 F.3d 997, 1002 (1st Cir. 1996) ("As a federal agency charged with administering the Medicaid program, HCFA plainly is entitled to *Chevron* deference in its interpretations of the Act and the implementing regulations"), *cert. denied*, 117 S. Ct. 955 (1997).[10/] For many years, HCFA has stressed the importance of allowing States the flexibility to administer their Medicaid programs. The goal of the regulations that HCFA has chosen to promulgate under § 1396a(a)(30)(A) is cost-

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[10/] *See also Folden v. Washington State Dep't of Soc. and Health Servs.*, 981 F.2d 1054, 1058 (9th Cir. 1992); *Missouri Dep't of Social Servs. v. Sullivan*, 957 F.2d 542, 544 (8th Cir. 1992); *Illinois Council on Long Term Care v. Bradley*, 759 F. Supp. 1309, 1311–12 (N.D. Ill. 1991), *aff'd* 957 F.2d 305 (7th Cir. 1992).

containment; these regulations do not include any requirements even remotely similar to what the Ninth Circuit has now imposed. *See* 42 C.F.R. §§ 447.304, 447.321–447.334, 447.361.

Nor did the Ninth Circuit accord any deference to California's application of § 1396a(a)(30)(A). The Ninth Circuit all but ignored the enormous administrative record compiled by the State in reviewing compliance of its outpatient rates with § 1396a(a)(30)(A). The record demonstrates that the State made a thorough and searching inquiry concerning the elements listed in § 1396a(a)(30)(A). The district court found that the record "amply demonstrates the rational relationship between each rate change and the relevant factors" of § 1396a(a)(30)(A). Pet. App. B–19.[11/]

In holding that *Chevron* deference does not apply to the State's application of the federal statute, the Ninth Circuit erroneously relied on a standard from the Second Circuit decision in *Turner v. Perales*, 869 F.2d 140, 141 (2d Cir. 1989) (per curiam), that even the Second Circuit does not apply in the Medicaid context. Pet. App. A–11 to A–12. In *Turner*, the court declined to defer to a state's construction of a federal housing law. But the Second Circuit recently held

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[11/] In response to public comment focused on hospital costs, California commissioned a lengthy study comparing Medicaid rates to hospital costs (while preserving its position that such a study was not necessary). The study results lent strong support to California's rate structure, for they demonstrated that the State's Medicaid reimbursement rates covered the costs of efficient hospitals. Pet. App. A–10, B–6. Despite the fact that California prepared the very type of cost study that the Ninth Circuit found that States are required to undertake under § 1396a(a)(30)(A) and considered it in determining that its rates were lawful, the Ninth Circuit still found the State's actions to be unlawful because California did not base its rate decision on the cost study. Pet. App. A–22.

in *Perry v. Dowling*, 95 F.3d 231 (2d Cir. 1996), that *Turner* did not apply to the review of a state agency's compliance with the Medicaid Act. The court in *Perry* reasoned that "Medicaid is a joint federal-state program that requires, among other things, HHS approval of state Medicaid plans and their implementation.... Thus, here, unlike in *Turner*, a federal agency is involved." *Id.* at 236. In addition, the Second Circuit reasoned that the Medicaid statutory scheme contemplates that States will implement and operate the Medicaid program once it has been approved by HHS. *Id.* Citing *Chevron*, the Second Circuit concluded: "In these circumstances, in which the state has received prior federal-agency approval to implement its plan, the federal agency expressly concurs in the state's interpretation of the statute, and the interpretation is a permissible construction of the statute, that interpretation warrants deference."[12/] *Id.* at 237.[13/]

[12/] California's procedure for adopting and modifying non-institutional provider rates is set forth in its State Plan and has been approved by HCFA.

[13/] The Ninth Circuit also relied on *AMISUB (PSL), Inc. v. Colorado Dep't of Social Servs.*, 879 F.2d 789 (10th Cir. 1989), but that decision arose under the Boren Amendment, which has been construed by some courts as limiting States' discretion in setting institutional rates. Even so, *AMISUB* has been characterized in a more recent Tenth Circuit decision as an "extreme case." *Kansas Health Care Ass'n v. Kansas Dep't of Soc. Rehabilitations Servs.*, 958 F.2d 1018, 1022 (10th Cir. 1992). It is also at odds with other courts of appeals that have found that federal courts should apply a deferential standard of review, even in the Boren Amendment context, in determining whether Medicaid rates comply substantively with federal law. *See, e.g., Illinois Health Care Ass'n v. Bradley*, 983 F.2d 1460, 1462-63 (7th Cir. 1993); *West Virginia Univ. Hosps. v. Casey*, 885 F.2d 11, 23 (3d Cir. 1989); *Colorado Health Care Ass'n v. Colorado Dep't of Soc. Servs.*, 842 F.2d 1158, 1164-65 (10th Cir. 1988); *Mississippi Hosp. Ass'n v. Heckler*, 701 F.2d 511, 516 (5th

(continued...)

Following the *Chevron* principle is particularly important in this case where the Medicaid scheme at issue is highly complex and technical,[14] the responsible agencies considered the matter in a detailed and reasoned way, and the decision involves reconciling conflicting policies. *See Chevron*, 467 U.S. at 865. Judicial deference in the area of complex health policy is vital because "[j]udges are not experts in the field," and "policy arguments are more properly addressed to legislators or administrators, not to judges." *Id.* at 864–65.

Moreover, the Ninth Circuit's imposition of a new procedural requirement that is not contained in the statute or its regulations—requiring the state to undertake and rely on cost studies—is contrary to the decisions of this Court that stand for the principle that courts may not impose procedural requirements on agencies. This Court has recognized that judges should not "engraft[] their own notions of proper procedures upon agencies entrusted with substantive functions by Congress." *Vermont Yankee Nuclear Power Corp. v. Natural Resources Defense Council, Inc.*, 435 U.S. 519, 520 (1978); *see also PBGC v. LTV Corp.*, 496 U.S. 633, 654 (1990) ("*Vermont Yankee* stands for the general proposition that courts are not free to impose upon agencies specific procedural requirements that have no basis in [a statute]"). This principle applies in non-APA cases such as this one, *id.* at 524, and its rationale is equally applicable where the Act of Congress contemplates that the State will exercise substantive

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[13](...continued)
Cir. 1983); *cf. Wilder*, 496 U.S. at 520 n.18 (noting that courts of appeals generally had "employ[ed] a deferential standard of review to evaluate whether the rates comply with the substantive requirements of the [Boren] amendment.").

[14] Section 1396a(a)(30)(A) is one of over sixty different criteria that a State Plan must address. *See* 42 U.S.C. § 1396a(a)(1)–(62).

functions pursuant to policies enunciated in federal law, as is the case with the Medicaid Act.

The principles set forth by this Court to guide judicial review of administrative decisionmaking apply with particular force in this case. Medicaid is a "cooperative federal-state program," *Wilder*, 496 U.S. at 502, and federal courts should be especially reluctant to impose requirements on state agencies that have no basis in the statute, regulations, legislative or administrative history. This is especially true here where a goal of the statutory provision in question is to increase the flexibility of States and to reduce its administrative burdens. The Ninth Circuit's interpretation of § 1396a(a)(30)(A) turns this goal on its head.

III. SECTION 1396a(a)(30)(A) DOES NOT CREATE INDIVIDUAL RIGHTS ENFORCEABLE BY HEALTH CARE PROVIDERS UNDER 42 U.S.C. § 1983.

The second issue for which California seeks this Court's review is whether § 1396a(a)(30)(A) creates individual rights judicially enforceable by health care providers under 42 U.S.C. § 1983. The State argued in the district court that § 1396a(a)(30)(A) was not judicially enforceable, but the district court rejected the argument. Pet. App. B–7 to B–9. Because the State prevailed at the district court level on the merits, it did not press the issue of enforceability on appeal to the Ninth Circuit. Nonetheless, this Court is free to grant review of this second issue in addition to granting review of the first issue raised by the State. *See Office of Personnel Management v. Richmond*, 496 U.S. 414 (1990), *particularly* 496 U.S. at 440–41 (Marshall, J., dissenting); *see also Teague v. Lane*, 489 U.S. 288, 300 (1989).

Although this brief does not address this second issue in detail, we do point out that, following its decision in *Wilder*,

this Court held in *Suter v. Artist M*, 503 U.S. 347, 360 (1992) that the "reasonable efforts" clause of the Adoption Assistance and Child Welfare Act of 1980, 42 U.S.C. § 671(a)(15) is not enforceable through an action under § 1983 because there is "no further statutory guidance ... as to how 'reasonable efforts' are to be measured." This holding in *Suter* was not disturbed by the post-*Suter* legislation discussed in the opinion of the district court. Pet. App. B–8. Like the provision at issue in *Suter*, § 1396a(a)(30)(A) lacks sufficient specificity and detail to create an enforceable right under § 1983. Enforcement of such undefined statutory standards as "consistent with efficiency, economy and quality of care" "strain[s] judicial competence." *See Blessing v. Freeman,* 1997 U.S. LEXIS 2506 at *28 (April 21, 1997) (internal quotations omitted) (holding that § 1983 does not permit suits by beneficiaries of Title IV–D of the Social Security Act to challenge a State's failure to achieve "substantial compliance" with the requirements of that Title).[15/]

The Ninth Circuit's decision underscores the difficulties that are presented when courts attempt to enforce as an individual federal right such a general provision as § 1396a(a)(30)(A). Given the lack of objective benchmarks in that statutory provision and its accompanying regulations to guide judicial enforcement, the State *amici* are concerned that it will be impossible to achieve a consistent application of the statute in private actions brought by providers. Inconsistencies in judicial application, as seen in the

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[15/] In *Wilder*, the Court held that the Boren Amendment is enforceable under § 1983 because of its use of the "objective benchmark" of provider costs for measuring the adequacy of payment. 496 U.S. at 519. As explained above, § 1396a(a)(30)(A) contains no such "objective benchmark"; its standards are far less concrete and less susceptible to judicial enforcement than those set forth in the Boren Amendment and its implementing regulations.

conflicting decisions of the Seventh, Eighth, and Ninth Circuits, undermine the States' important need for certainty in administering their Medicaid programs.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted,

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